

CONNECTICUT INSURANCE ASSISTANCE PROGRAM FOR AIDS PATIENTS (CIAPAP)

- Do you or a dependent have AIDS or an AIDS-Related disease?
- Do you have health insurance through your job?
- Are you in danger of losing that insurance because you may become unemployed?

If so, the Connecticut Insurance Assistance Program may be able to help you. Please read the following information to learn more.

What is the CIAPAP?

It's a program to help persons with AIDS take advantage of a federal law which allows for an extension of employer-provided group health insurance to persons who become unemployed. If you or an eligible dependent qualify, the Connecticut Department of Social Services can pay for extended insurance premiums to the extent allowed by state and federal law. You must act quickly because you only have a limited time to choose the extended coverage. If you are already participating in extended health coverage and you qualify, the department can begin paying your health insurance premiums.

Who Qualifies for the Connecticut Insurance Assistance Program?

You must meet certain financial, medical and other requirements in order to receive help with your health insurance premiums.

Financial

Your family income must be less than the amounts in the following tables. Income includes unearned income (such as unemployment compensation, Social Security disability or retirement benefits) and earned income (such as wages, tips and other compensation).

You will be allowed to deduct from your gross income the costs of insurance premiums and unpaid medical expenses incurred only during the month you apply.

<u>Family Size</u>	<u>Monthly Income Limit</u>
1	\$1,552
2	\$2,082
3	\$2,612
4	\$3,142

For more information on income limits for larger families, please call 1-800-842-1508.

You and your family must have less than \$10,000 in countable assets. Assets which will count toward the asset limit include cash on hand, bank accounts, stocks, bonds and severance pay. Your home will not be counted as an asset.

Medical Requirements

You must be diagnosed, by a physician, as having AIDS (Acquired Immunodeficiency Syndrome).

An applicant must be eligible for an extension of employer-provided health insurance benefits that are offered when the insured person becomes unemployed.

How to Apply

Under federal law, you have only 60 days from the date your insurance coverage ends or the date your employer tells you about the extended coverage, whichever is later, to apply for the federal extension. Under state law, if you work for an employer with less than 20 employees, you have only 30 days. If you ask your employer for the extended health insurance coverage after the 30/60 days, you may not qualify for it. After you choose the extended coverage, a premium payment must be made within 45 days, so it is very important that you apply for the Connecticut Insurance Assistance Program as early as possible.

You can apply by completing the attached forms and returning them to the Department of Social Services, **ATTN: Adult Support**, 25 Sigourney Street, Hartford, CT 06106-5033. If there are no forms attached to this sheet, please call us toll-free at 1-800-842-1508, and we will be happy to mail you an application. All information is completely confidential.

You must provide proof of your family's income and assets. You can attach the proof to your application; if it is not immediately available, you must send it to us within 10 days. Please see the attached material to learn what proof of income and assets can be submitted.

You must give us proof that you qualify for the extended insurance coverage and that you have requested the coverage. ***This proof can be a copy of the notice your employer gave to you about the coverage and a copy of the notice showing you applied for the coverage.*** If these are not available, you can submit written statements showing this information. Please see the attached material for more details.

We will notify you in writing of our decision on your application. If your application is approved, we will review your case in six months to see if you still qualify.

What is the Amount of Benefits Paid by the State?

If you qualify under federal law, we can pay your health insurance premium for up to 18 months. If you apply for Social Security disability benefits and are found eligible within the first 60 days after continuation coverage begins, you can receive another 11 months of coverage for a total of 29 months.

Under state law, if you worked for an employer with less than 20 employees, the health insurance premium can be paid for up to 36 months.

The state will pay premiums only for the person who is eligible for this program. If the insurance premium includes an amount for family coverage, the state will pay only the part of the premium which covers the eligible individual who has AIDS.

If you are dissatisfied with the department's action, you have the right to request an appeal of the decision. You can request this appeal by writing to ask for a hearing. Send your written request for a hearing to: Office of Legal Counsel, Regulations, and Administrative Hearings, State of Connecticut, Department of Social Services, 25 Sigourney Street, Hartford, CT 06106-5033. You may also call (860) 424-5760 or toll free 1-800-462-0134 for more information regarding a hearing.

If you would like more information about the Insurance Assistance Program, please call 1-800-842-1508.

Services are available to all applicants and recipients without regard to race, color, sex, age, physical or mental disability, religious creed, national origin, sexual orientation, ancestry, language barriers or political beliefs. Deaf and hearing impaired individuals may use a TDD/TTY by calling 1-800-842-4524. Questions, concerns, complaints or requests for information in alternative formats must be directed to the Government and Public Relations Office at (800) 842-1508. The Department of Social Services is an equal opportunity, affirmative action employer.



APPLICATION FOR CONNECTICUT INSURANCE ASSISTANCE PROGRAM FOR AIDS PATIENTS

(PLEASE PRINT) PLEASE COMPLETE AND RETURN THIS FORM TO 25 SIGOURNEY STREET, HARTFORD, CT 06106-5033
ATTN: ADULT SUPPORT.

APPLICANT PERSONAL INFORMATION

Last Name _____ First Name _____ M.I. _____ Sex: ☐ M ☐ F

Social Security No. _____ Date of Birth ____/____/____

Street Address _____ City _____ State _____ Zip _____

Tel. No. _____

List any of the following persons living with you:

Spouse _____ Your Children Under 18 _____

Parents (if you are under 18) _____

Total number of above persons including applicant _____

FAMILY INCOME AND ASSETS

Monthly income of applicant before taxes after employment ends:

Amount
(Indicate if Monthly,
Weekly or every two weeks)

Source

Monthly income before taxes of other family members listed above: (If employed indicate employer name and address under source)

Name

Amount

Source

Total family monthly income before taxes _____

Assets of applicant and family members:

	Amount	Owner
Total Cash		
Checking Account		
Bank Savings		
Value of Stocks		
Value of Bonds		
Severance Pay: _____	Total Assets: _____	

EMPLOYMENT INFORMATION

Name of the present/last employer through which applicant has medical coverage:

Employer Address _____ City _____ State _____ Zip _____

Tel. No. _____ Ending date of employment _____

Person Employed _____

HEALTH INSURANCE INFORMATION *(to be completed only at initial application)*

Ending date of Health Insurance coverage _____

Date you elected to continue your coverage. (Date you notified in writing Employer/Plan Administrator that you choose to continue coverage) _____

Insurance Company _____ Group No. _____ Policy No. _____

Premium amount to continue coverage for Applicant Only \$ _____*(TO CONTINUE COVERAGE FOR DEPENDENTS YOU MUST MAKE PAYMENTS DIRECTLY TO EMPLOYER/PLAN ADMINISTRATOR)*

If known, date of first payment _____ Premium Due: Monthly _____ Quarterly _____

Premium check payable to: _____

Name

Mail Premium payment to:

Name _____ Street _____

City _____ State _____ Zip _____

IF AVAILABLE, ATTACH A COPY OF THE BILL YOU RECEIVED TO CONTINUE COVERAGE

If we can't reach you, is there someone we can speak with concerning your participation in this program?

☐ Yes ☐ No Name: _____ Telephone # _____Can we leave a message with this person? ☐ Yes ☐ No**Insured's Statement:**

I certify that the information I have supplied is true and accurate to the best of my knowledge and I understand that this information is subject to verification by the State. I agree to release to the Department of Social Services any financial, insurance and medical records the Department may need to administer the program. I agree to notify the Department within 10 days if I return to work or if there is any change in my income, assets or family size.

I understand that if I am not satisfied with the action taken, I have the right to request a hearing within 60 days from the date of notice of action by writing to Office of Legal Counsel, Regulation, and Administrative Hearings, State of Connecticut, Department of Social Services, 25 Sigourney Street, Hartford, Connecticut 06106-5033. I may also call (860) 424-5760 or toll free 1-800-462-0134 for more information regarding a hearing.

Signature _____ Date _____
*(Applicant or Parent of applicant if under 18 years of age)***CONNECTICUT AIDS DRUG ASSISTANCE PROGRAM (CADAP)**

CADAP can pay for certain drugs used to treat HIV/AIDS related conditions. You may be eligible for this assistance.

Do you wish to apply for CADAP assistance? ☐ Yes ☐ No

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.

CONNECTICUT INSURANCE ASSISTANCE PROGRAM FOR AIDS PATIENTS

(PLEASE PRINT) PLEASE COMPLETE AND RETURN THIS FORM TO 25 SIGOURNEY STREET, HARTFORD, CT 06106-5033
ATTN: ADULT SUPPORT.

APPLICANT

Last Name _____ First Name _____ M.I. _____
Street Address _____ City _____ State _____ Zip _____
Telephone No. _____

I hereby authorize this physician to release to the Department of Social Services my medical records needed for the administration of this program. _____

Signature *Date*
(Applicant or Parent of applicant if under 18 years of age)

TO BE COMPLETED BY APPLICANT'S PHYSICIAN:

Physician's Last Name _____ Physician's First Name _____
Office Address _____ Town _____ State _____ Zip _____
Telephone No. _____ Physician's License No. _____

In addition to a positive lab test indicating the presence of the HIV virus, this person has been diagnosed with one or more of the following conditions: *(Please Circle YES or NO for Each Condition.)*

YES	NO	CD4 + T-lymphocyte count < 200	YES	NO	Histoplasmosis
		cells per UL or a CD4 + percent < 14	YES	NO	Other Mycobacteriosis
		of total lymphocytes	YES	NO	Tuberculosis
YES	NO	Cryptosporidiosis	YES	NO	Pneumocystis Carinii
YES	NO	Candidiasis	YES	NO	Pneumonia, Recurrent
YES	NO	Progressive Multifocal	YES	NO	Chronic Anemia due to HIV
		Proleukoencephalopathy			Disease
YES	NO	Cytomegalovirus	YES	NO	HIV Wasting Syndrome
YES	NO	Lymphoid Interstitial Pneumonia (LIP)	YES	NO	Other Bacterial Infection
YES	NO	Coccidioidomycosis	YES	NO	Herpes Simplex Virus
YES	NO	HIV Encephalopathy (Dementia)	YES	NO	Lymphoma
YES	NO	Isosporiasis	YES	NO	Renal Disease (ESRD)
YES	NO	Peripheral Neuropathy	YES	NO	Idiopathic Thrombocytopenia
YES	NO	Cryptococcosis			(ITP)
YES	NO	Persistent Generalized	YES	NO	Thrombocytopenic Puerpura
		Lymphadenopathy			(TTP)
YES	NO	Kaposi's Sarcoma	YES	NO	HIV Cardiac Disease
YES	NO	Toxoplasmosis	YES	NO	Invasive Cervical Cancer
YES	NO	Salmonellosis	YES	NO	Other Cancer Not Listed
YES	NO	Aphthous Ulcers	YES	NO	Pancreatitis of Unknown Origin

Physician's Statement:

I certify that the above medical information is true and accurate to the best of my knowledge. I also agree to furnish the Department with the patient's medical history, including laboratory results, if necessary to verify eligibility for the program.

Signature

Date

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

**CONNECTICUT INSURANCE ASSISTANCE PROGRAM FOR AIDS PATIENTS
(CIAPAP)**

You must provide proof of certain information in order to become eligible and remain eligible for CIAPAP assistance.

At the time of application only:

You must provide proof that your employer has offered and that you have accepted continuing health insurance coverage. You can provide any of the following:

- a copy of the notice you received from your employer or health care plan administrator letting you know that you can continue your group health coverage.
- a copy of your written acceptance of continued health coverage.
- a written statement from your employer or health plan administrator that provides the date that you stopped working, the date that health insurance coverage ends and the date that you told your employer/ administrator that you want continued coverage.

At the time of application and redetermination:

You must provide proof of:

- income for any family member. The proof may be things such as the most recent pay stub, a statement from the employer, a copy of a disability check or an award letter.
- assets for any family member. Proofs may include bank statements, credit union statements, copies of certificates of deposit, copies of stocks and/or bonds.
- medical expenses. This would include copies of medical bills that are not covered by insurance for services received in the month of application or redetermination only and copies of unpaid insurance premiums.

If you have any questions or want more information, call our toll-free hot line at 1-800-842-1508.